ARKANSAS STATE BOARD OF DENTAL EXAMINERS
101 East Capitol Avenue, Suite 111
Little Rock, Arkansas 72201
Phone: 501-682-2085 Fax: 501-682-3543
Web: www.asbde.org Email: asbde@arkansas.gov

For Board Use Only:

Permit #: _____

DOL: _____

REGISTRATION FOR DENTAL ASSISTANTS

FOR THE REGISTRATION OF DENTAL ASSISTANTS IN THE EXPANDED DUTIES OF: **RADIOGRAPHY**, **POLISHING**, **NITROUS OXIDE ADMINISTRATION** AND **SEDATION MONITORING**

Please type or print legibly. A copy of your current *Healthcare Provider* level CPR card must accompany this application. Failure to complete this form correctly will delay your permitting process.

Fee is $20 for *EACH* expanded duty.

Radiography-$20	**Coronal Polishing**-$20
Nitrous Oxide-$20	**Sedation Monitoring**-$20

A. Personal Data

First Name Middle Name Maiden Name Last Name

Address: (Street or PO Box) City State Zip

Social Security Number Home Phone Business Phone

Date of Birth Email Address County

B. For Radiography and Polishing Registration

NOTE: This section is only to be completed by your Arkansas-licensed supervising dentist.

I have carefully observed and tested the above named dental assistant. In my judgment, the dental assistant is competent to perform the expanded duty(s) checked below under my personal supervision:

☐ Radiography
☐ Polishing

Dentist's Name (Please print) License Number Date

Dentist's Signature

C. For Nitrous Oxide Administration &/OR Sedation Monitoring Registration

Name of Nitrous Oxide Course Instructor _____ Date of Course _____

Name of Sedation Monitoring Course Instructor/Program _____ Date of Course _____

Note: You must provide proof of completion of course(s) with this application. Only courses from Board-approved instructors/programs will be accepted.

D. For Certified Dental Assistants (CDAs) or Dental Assisting School Graduates

CDA Certification Number _____ Expiration Date _____

Name of CODA-accredited Dental Assisting School _____ Date Graduated _____

Note: You must provide a copy of your current CDA credentials or a copy of your diploma from your dental assisting school. Only programs from CODA-accredited schools will be accepted.

In addition to the foregoing:

1. I hereby give my permission for the Arkansas State Board of Dental Examiners to secure information concerning me or any of the statements in this application from any person or any source the Board may desire.

2. I further agree to submit to questions concerning my qualifications as an applicant by the Board or any member thereof, and to substantiate my statements if desired by the Board.

3. I agree to read the Dental Practice Act of Arkansas and the Rules & Regulations of the Board pertaining to Dentistry, Dental Hygiene and Dental Assisting; and I further state that all facts, statements, and answers contained in this application are true and correct; I am not omitting any information which might be of value to this Board in determining my qualifications, whether it is called for or not; and I agree that any falsification, omission or withholding of pertinent information or facts concerning my qualifications as an applicant shall be sufficient to bar me from licensure by the Arkansas State Board of Dental Examiners and such falsification, omission, or withholding shall serve as sufficient grounds for the revocation, cancellation, or suspension of my Arkansas Dental Assistant Permit if it is not discovered until after issuance.

Signature of Dental Assistant _____ Date _____